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22 Independent Radiology

The policy provisions for radiology providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 34.

22.1 Enrollment

EDS enrolls Independent Radiology providers and issues provider contracts to applicants who meet the licensure and certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as an Independent Radiology provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for radiology-related claims.

NOTE:

All nine digits are required when filing a claim.

Independent Radiology providers are assigned a provider type of 10 (Independent Radiology). Valid specialties for Independent Radiology providers include the following:

- Mammography (M7)
- Nuclear Medicine (36)
- Physiological Lab (Independent Diagnostic Testing Facility) (66)
- Portable X-Ray Equipment (63)
- Radiology (30)

Enrollment Policy for Independent Radiology Providers

To participate in Medicaid, Independent Radiology providers must meet the following requirements:

- Possess certification as a Medicare provider
- Possess a Physician's Supervisory Certification and utilize certified technicians for ultrasounds, Doppler services, and non-invasive peripheral vascular studies if a physiological labs
- Exist independently of any hospital, clinic, or physician's office
- Possess licensure in the state where located, when it is required by that state
- For mammography services, possess a certification issued by the FDA.

22.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Radiology services are professional and technical radiological services, ordered and provided under the direction of a physician or other licensed practitioner of the healing arts. Within the scope of his practice as defined by state law and are provided in an office or similar facility other than an outpatient department of a hospital or clinic and meets the requirements for participation in Medicare. Radiology services are restricted to those that are described by procedures in the CPT manual. Providers will be paid only for covered services, which they actually perform.

An Independent Radiology provider may perform diagnostic mammography, a radiological procedure furnished to a man or woman with signs or symptoms of breast disease, a personal history of breast cancer, or a personal history of biopsy-proven benign breast disease. A diagnostic mammogram includes a physician's interpretation of the results of the procedure. Services are unlimited, but should be billed with procedure codes 76090 and 76091.

An Independent Radiology provider may perform screening mammography, a radiological procedure furnished to a woman without signs or symptoms of breast disease for the purpose of early detection of breast cancer. A screening mammogram includes a physician's interpretation of the results of the procedure. Services are limited to one screening mammogram every 12 months for women ages 50 through 64. This screening should be billed under procedure code 76092.

22.3 Prior Authorization and Referral Requirements

Radiology procedure codes generally do not require prior authorization. Any service warranted outside of these codes must have prior authorization. Refer to chapter 4, Obtaining Prior Authorization, for general guidelines.

Services performed by an independent radiologist for those recipients enrolled in the Patient 1st Program **do not require a referral** from the Primary Medical Provider (PMP).

Procedure codes performed as a result of an EPSDT screening require an EPSDT screening referral form in the patient's medical record. Refer to Appendix A, EPSDT, for more information on obtaining a referral through the EPSDT Program.

22.4 Cost Sharing (Copayment)

Copayment amount does not apply to services provided by Independent Radiology providers.

22.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, provider should bill Medicaid claims electronically.

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

Radiology providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a HCFA-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

22.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Independent Radiology providers to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

22.5.2 Diagnosis Codes

For dates of service 01/01/99 and after, valid diagnosis codes **are required**. The International Classification of Diseases - 9th Revision - Clinical Modification (ICD-9-CM) manual lists Medicaid required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P. O. Box 10950, Chicago, IL 60610.

For dates of service prior to 01/01/99, Independent Radiology providers are not required to provide valid diagnosis codes. Providers must bill diagnosis code V729 on hard copy and electronically submitted claims.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

22.5.3 Procedure Codes and Modifiers

Radiology providers use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

Radiology Facilities are limited to billing CPT radiology procedure codes. The range of codes is 70010 through 79999. Physiological labs are **restricted** to the codes listed in their contract with Medicaid.

Professional and Technical Components

Some procedure codes in the 70000, 80000, 90000, and G series are a combination of a professional component and a technical component. Therefore, these codes may be billed three different ways; (1) as a global, (2) as a professional component, or (3) as a technical component.

- **Global**, the provider must own the equipment, pay the technician, review the results, and provide a written report of the findings. The procedure code is billed with no modifiers.

- **Professional component**, the provider does not own the equipment. The provider operates the equipment and/or reviews the results, and provides a written report of the findings. The Radiological professional component is billed by adding modifier 26 to the procedure code, and should be billed only for the following place of service locations:
  - 21 (inpatient)
  - 22 (outpatient)
  - 23 (emergency room - hospital)
  - 24 (ambulatory surgical center)
  - 32 (nursing facility)
  - 51 (inpatient psychiatric facility)
  - 61 (comprehensive inpatient rehab facility)
  - 62 (comprehensive outpatient rehab facility)
  - 65 (end stage renal disease facility)
- **Technical component**, the provider must own the equipment, but does not review and document the results. The technical component charges are the facility's charges and are not billed separately by physicians. The technical component is billed by adding modifier TC to the procedure code.

22.5.4 Place of Service Codes

The following place of service code applies when filing claims for radiology services:

POS Code	*Description*
99	Other Unlisted Facility

22.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:

When an attachment is required, a hard copy HCFA-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

22.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
HCFA-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N